MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

November 7-8, 2002

An introduction to how Medicare makes coverage decisions

ISSUE: What process does Medicare use to make coverage decisions of new and existing medical services? What concerns have been raised about how Medicare makes its coverage decisions?

KEY POINTS: Medicare makes explicit coverage decisions through the national coverage determination process and locally by Medicare's contractors. In addition, CMS's payment and coding guidelines, published in the agency's interpretive manuals and program memorandum, can become *de facto* coverage decisions.

Policy and operational issues that have been raised concerning how Medicare makes coverage decisions include:

- Should the value of a service explicitly be considered during the coverage process or the payment process? What are the consequences– on beneficiaries' access to care, providers' ability to furnish care, and manufacturers' incentives to invest in research and development–if Medicare considers a service's value when making coverage or payment decisions?

- Why do local coverage policies vary across and between regions? Does variation in local policies affect beneficiaries' access to care and providers' ability to furnish high-quality care? Is there a role for variation in Medicare's local coverage policies during the early stages of the development of a medical service?

- Has the availability of resources affected the ability of CMS and its contractors to make timely coverage decisions?

- Will increased collaboration between CMS and the Food and Drug Administration improve the ability of CMS and its contractors to make evidence-based, timely coverage decisions?

ACTION: Staff would appreciate feedback about whether Commissioners would like to consider examining in greater depth the coverage-related policy and operational issues raised in these briefing materials.

STAFF CONTACT: Nancy Ray (202-220-3723), Chantal Worzala (202-220-3718), Joan Sokolovsky (202-220-3720).